WELL SENSE HEALTH PLAN

January 6, 2020

State of New Hampshire
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3852
Via email: DHHS-contracts@dhhs.nh.gov
ami.carvotta@dhhs.nh.gov

Re: Letter of Transmittal for the State of New Hampshire, Department of Health and Human Services (DHHS) Request for Information #RFI-2020-DBH-01-MOBIL

Dear Ms. Guimond:

Boston Medical Center Health Net Plan (BMCHP)-Well Sense Health Plan and our behavioral health partner, Beacon Health Options,d.b.a.. Beacon Health Strategies (Beacon), is pleased to submit this response to your Request for Information (RFI) reagarding Mobile Crisis Services. In this submission we provide our response to your questions regarding development of a new statewide model for the expansion and integration of Mobile Crisis Response Teams (MCRT) throughout New Hampshire.

In addition, pursant to Section 7.3.1.1.1.2, we provide the following information:

Organizational Information		Respondent Representative Contract Information	
Organization Name	Well Sense Health Plan	**Name**	Kevin Wheeler MD
Organization Address	1155 Elm Street, Suite 600, Manchester, NH 03101	**Title**	Interim Executive Director, Medical Director
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Statewide Mobile Crisis Response Teams

Request for Information # RFI-2020-DBH-01-MOBIL

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Executive Summary

7.3.1.1.3.1. Provide DHHS with an overview of the Respondent's organization;
7.3.1.1.3.2. Demonstrate the Respondent's understanding of the potential solutions described in this RFI and any anticipated problems associated with each;
7.3.1.1.3.3. Show the Respondent's overall design of the potential solution(s); and
7.3.1.1.3.4. Specifically demonstrate the Respondent's familiarity with the potential solutions' elements, and the Respondent's solutions to the problems presented.

BMCHP-Well Sense Health Plan (Well Sense) is a not-for-profit 501(c)(3) tax exempt corporation licensed and operating as a Health Maintenance Organization in New Hampshire. The legal name of our corporation is Boston Medical Center Health Plan, Inc. (BMCHP). BMCHP does business in New Hampshire under the name Well Sense Heath Plan and in Massachusetts under the name Boston Medical Center HealthNet Plan (or BMC HealthNet Plan). For more than 20 years, our organization has managed and administered the benefit plans for low income and underserved individuals in Massachusetts and, since December 2013, we have served New Hampshire Medicaid members. In Massachusetts and New Hampshire combined, almost 80% of our membership is comprised of Medicaid Members.

Well Sense and our behavioral health partner, Beacon Health Strategies (Beacon), have successfully collaborated with DHHS for over five years as one of New Hampshire's Medicaid Care Management (MCM) plans. We currently serve over 86,000 New Hampshire Medicaid Members by offering accessible, person-centered and culturally competent care through our statewide contracted network of providers. Our organizational culture embraces continuous quality improvement, collaboration, ownership, accountability and transparency. We operate as an integral part of the New Hampshire communities we serve, employing staff who live, work and play in the State and know the local landscape and needs of our Members and other stakeholders in the MCM program. As such, we are well positioned to recognize that comprehensive, coordinated mobile crisis services are a core component within a fully developed behavioral health system of care. Ineffective or insufficient crisis services leads to hospitalization rather than linkage to effective community services that can allow persons to stay in their homes.

Well Sense, with Beacon, is pleased to provide the New Hampshire Department of Health and Human Services (DHHS) this response to your RFI for Statewide Mobile Crisis Response Teams. Access to mobile behavioral health care is critical for the overall performance of the health care delivery system and is important for containing costs. Well Sense and Beacon recognizes the value that mobile crisis teams bring in helping to keep care in the community and facilitating the placement of members in treatment. In Massachusetts, we continue to work with the Executive Office of Health and Human Services (EOHHS) and the Massachusetts Association of Health Plans (MAHP) to

redesign the behavioral health delivery system in a way that ensures patients and families have access to the services that they need, when they need them.

Beacon has 30 years of crisis system experience whereby they have refined and improved their crisis philosophy and approach, focusing on person centered, trauma-informed resolution rooted in evidence based practices. Beacon employs more than 4,500 individuals throughout the U.S. to support partnerships with state behavioral health and Medicaid authorities, counties, and health plan clients. Beacon's national team of behavioral health experts transact at the local level whereby bringing scale contextualized into local communities. **As such, Beacon's independent response to the DHHS RFI for Statewide Mobile Crisis Response Teams is reflective of more extensive national exposure, experience and expertise, and will be offered under a different cover.**

Nationally and in New Hampshire, the demand for comprehensive crisis services has never been greater. As a direct result of limited access to community based crisis services, ED visits and inpatient admissions have become the primary locations for treatment. Patient acuity increases when appointments are not readily available to mitigate a crisis. When members do not know where to turn they end up in the Emergency Department (ED). With the 4th highest rate of opioid overdose deaths, New Hampshire's investments in the Doorways program and expanding access to medication assisted treatment has been laudable, but more work needs to be done, particularly in rural communities, to move individuals beyond assessments and drive increased timely access to substance use treatment services allowing patients to receive care in their home communities.

Comprehensive crisis systems have proven ability to improve health and wellness outcomes, quality of life, and cost of care to the system. We can no longer view crisis services as just those services that respond to a crisis in real-time. An effective crisis system goes beyond stabilization to focus on prevention, recovery and resiliency over hospitalization or detention. To do so, crisis services integrate into a wider array of community-based behavioral health services where every interaction presents an opportunity for meaningful engagement in the larger health and social services system. Effective crisis services require system management and oversight that includes a technology infrastructure to facilitate access, track available services, connect system Providers and stakeholders, share data and measure outcomes.

We propose building a crisis solution around a system that supports individuals through all phases that lead up to and following a crisis episode. The five phases of crisis system involvement around which we build our solutions are:

- Prevention
- Early intervention
- Acute intervention
- Crisis treatment

- Recovery and reintegration

Our approach focuses on the creation of that unified system, one that goes beyond acute triage and intervention and instead seeks to engage with individuals experiencing high risk of or early symptoms of behavioral health crisis. This occurs across all populations, payers and age bands. Through timely engagement and reduced reliance on acute intervention, comprehensive crisis systems become an effective tool in the redistribution of behavioral health access, focusing on early and upstream opportunities whenever possible. Person centered, acute crisis intervention capability is equally necessary. By focusing on the development of a crisis continuum that promotes remediation of the distress of the individual in crisis through connection to timely, evidence-based community treatment, the most effective interventions become attainable. A more rapid engagement of individuals into treatment when the need is first recognized is a key initiative to drive improved outcomes for individuals accessing behavioral health and substance use services.

As the DHHS undertakes a crisis enhancement it must be acknowledged that system development is not naturally occurring. It is iterative and it takes time to implement. Developing a crisis system in New Hampshire will require strong leadership and broad stakeholder engagement to ensure the vision for system transformation is broadcast widely and guard against defaulting to or entrenching into historic practices. Multiple entities are currently engaging with individuals who may be in crisis or are putting in place programs to support these individuals. These entities include the Community Mental Health Programs/Providers, the Doorways, the Integrated Delivery Networks (IDNs), Managed Care Organizations (MCOs), 211 and other entities. The ability to effectively coordinate across and through these currently disparate systems will drive the success of the crisis system and support DHHS goals of implementing an efficient and sustainable system that ensures timely access to mobile crisis response services statewide, and integrates with current emergency services to create a well-coordinated continuum of behavioral health crisis response services.

5.2. RFI Questions

Q1. *Briefly describe your organization, who you serve, and any experience/expertise specific to behavioral health crisis response services. Please keep generalized marketing material to a minimum.*

Well Sense and Beacon are mission-driven organizations committed to ensuring that individuals are able to live their lives to the fullest potential. We understand the needs of complex and underserved populations. Our organizations are built not only on clinical expertise but also on our own lived experience and commitment to interagency and coordination with state Medicaid programs to help shape comprehensive systems of care. Our mission and values drive everything we do. In this proposal we considered the challenges and strengths of NH communities, the existing system of care, Members, Providers, stakeholders and DHHS, Division for Behavioral Health Request for Information (RFI) objectives. In Massachusetts our organizations manage behavioral health services for adults with serious mental illnesses, substance use disorders (SUD), and co-occurring conditions, as well as children and youth with autism, in child welfare of juvenile justice, or transitioning to the adult system of care. We offer experience treating this vulnerable population through work with our parent organization Boston Medical Center (BMC), where behavioral health and substance use disorder urgent care models offer infrastructure for identifying and treating patients. Project ASSERT (Alcohol & Substance use Services, Education and Referral to Treatment) helps to screen and engage patients in treatment, and Faster Paths to Treatment serves as a medication bridge clinic (Project ASSERT: https://www.bmc.org/programs/project-assert) and Faster Paths to Treatment https://www.bmc.org/programs/faster-paths-to-treatment). Our work in Massachusetts demonstrates our ability to address challenges and find solutions across program models and agencies while serving the multi-system needs of Medicaid individuals.

Locally, Well Sense partnered with Beacon since the inception of the Managed Care Organization (MCO) program in 2013. Well Sense and Beacon work with New Hampshire Division of Behavioral Health and Community Mental Health Programs led to the design and implementation of a value based capitated contracting relationship that promotes and rewards best practices and quality improvements. Beacon also developed and implemented a Provider Quality Management (PQM) department to assure that all contracted behavioral health Providers and programs adhere to high quality efficacious best practices. Alternative Payment Methods in combination with PQM activities is innovative and cost effective while rewarding Provider efforts toward improved behavioral health care.

Nationally, Beacon manages Medicaid benefits on behalf of 14 million individuals across the country. Serving the Medicaid population for more than 20 years, including extensive work directly on behalf of state governments, Beacon has developed a wide range of

programs that help manage care for individuals with complex, comorbid conditions. Examples of those programs include, but are not limited to, intensive case management, acute residential treatment, home-based therapy, wraparound services, mobile crisis intervention, autism management, telehealth and Zero Suicide. In each State in which we work our contracts and solutions are tailored to the specific needs of the local communities accounting for differences in demographics, provider composition, geography and other local characteristics and infrastructure.

Beacon Crisis Response Experience

We bring DHHS deep and broad experience in mental health crisis response, including the administration of multiple statewide crisis systems through contracts with state and federal agencies. Examples of our experience include:

Beacon's clinical referral line, which is a core service offering, handles over 340,000 calls annually from individuals seeking assistance with behavioral health issues, including those who are in a self-defined crisis situation. In fact, approximately 20 percent of all calls received on our clinical referral line are from individuals who are experiencing a crisis.

- **National Clinical Referral Line**: Operated out of multiple locations, our national clinical referral line receives over 340,000 calls annually from individuals seeking assistance with behavioral health issues.
- **National Employee Assistance Program (EAP)**: Since 2011, Beacon has operated a national EAP program with access to licensed clinicians that receives nearly 400,000 calls a year.
- **Georgia**: Single-point-of-entry to services for the Georgia Crisis and Access Line that serves more than 10.5 million Georgians.
- **Washington**: Single coordinator of crisis services for 1.5 million residents in Clark, Skamania, Klickitat, Grant, Chelan, Douglas, Peirce, and Okanogan counties.
- **Colorado**: Operate an emergency response program in Colorado as part of our Regional Accountable Entity contract including a 24/7 crisis response services staffed with licensed behavioral health clinicians.
- **Massachusetts**: Single manager of the statewide Emergency Service Program (ESP) provider network, behavioral health crisis assessment, intervention, and stabilization services.

In Massachusetts, since 1996 Beacon has been managing the behavioral health needs of Medicaid members on behalf of the Commonwealth. As part of this contract Beacon worked with the Commonwealth to procure a redesigned Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) program. With the goals of community based care, hospital diversion, recovery-oriented services, and reducing health disparities, Beacon redesigned the system's core definition of emergency services from assessment and disposition (hospital screening) to a full-service crisis assessment, intervention, and stabilization service. The driving principle behind the ESP is to meet the person in the community, where he/she may be having a crisis, such as school, home, residential program, etc., or inviting the Member to an ESP community-based

location (CBL). It is that principle that propels the program's success. This program currently serves all uninsured and publicly insured youth and adults in the state. Today, Beacon continues to drive increased access and capacity of ESP/MCI as the system management entity responsible for managing the crisis system network of Providers, including measuring the performance of the system through response time, services location, disposition, and other additional data elements and quality indicators.

Q2. *Describe any experience/expertise or lessons learned operating mobile crisis response services and/or statewide integrated teams specific to the Factors to Consider listed in Section 4.*

When providing access to crisis services there are a number of lessons taken from experience across the country that can be applied to New Hampshire. First and foremost the expectation needs to be set that mobile services, provided in the community and available 24/7 are in fact the expectation. Our experience has shown that when given the opportunity for mobile response services to be provided in the emergency department (ED) it will begin to become the default location, negating the benefits a true mobile crisis intervention can provide and additionally increasing the strain on emergency departments already taxed with ED boarding issues.

Our experience in multiple systems highlights that program designs or clinical pathways that lead to the ED serve to increase ED boarding and negate the benefits of mobile crisis interventions. In many systems when a mobile crisis provider performs a community-based evaluation of an individual requiring an inpatient admission, the inpatient units often insist on "medical clearance" regardless of age, presentation or medical history. Thus, the individual must be sent to the ED, which defeats the purpose of community-based evaluation, increases costs to the system and delays the individuals access to timely behavioral health services. As New Hampshire considers expanding mobile and crisis services attention needs to be paid to developing medical clearance strategies to reduce the need for interim transport to emergency departments. One example of a potential strategy is to consider a mobile response innovation that pairs a behavioral health clinician and a nurse when there are key risk indicators. Specific strategies for that co-response could include offering screening for dementia, medication reconciliation/consulting with pharmacy, consideration of co-morbid conditions, and performing a nursing exam. This strategy could aid in developing a protocol that eliminates the need for ED medical clearance for several types of situations. Another example is the Emergency Treat and Transport (ET3) model being piloted by CMS with Medicare beneficiaries. Through ET3 CMS will reimburse ambulance Providers for transport to an alternative non-ED destination (such as a Doorway or behavioral health community based location) which was previously not reimbursable. Additionally, high

performing mobile crisis services feature 24/7/365 availability. As mental health crises do not conveniently occur during "business hours," a crisis system with less than 24/7 availability will actually promote accessing the ED. By expanding mobile crisis to 24/7 availability Providers are able to divert patients from the ED, accessing less restrictive levels or care or stabilizing the individuals in the community.

When considering mobile crisis services in rural areas it is critical that peers, telehealth, and hub and spoke models are employed to address the increased workforce and logistical challenges of rural communities. Peers as a stand-alone service, can be utilized for early crisis intervention and to support individuals recovery/reintegration. New England based models using peers to connect individuals to support connection to treatment include the Boston Public Health Commission's PAATHS (Providing Access to Addictions Treatment, Hope and Support). Best practice states like Washington or Arizona have adopted a policy of "regionalization" in which rural counties are regionalized with more urban/populous counties to create a larger risk pool and service area that can attract Providers/payers to serve an entire region. Telehealth capabilities can be leveraged through a hub and spoke model to allow psychiatry or nursing specialists to support the crisis teams responding in the community.

Q3. *Provide your recommended approach(s) for the provision of statewide mobile crisis response services. This could include a model for an integrated crisis continuum and should specifically indicate if services are proposed to be operated by a stand-alone entity or integrated into designated community mental health programs as a part of the continuum of crisis care. Specifically, how will the recommended model enhance, augment, strengthen, and/or expand existing resources?*

As indicated above, we believe strongly based on experience and exposure that high functioning crisis response systems that focus on ED based processes serve to increase ED boarding and negate the benefits of mobile crisis interventions. In New Hampshire too many inpatient admissions are driven through the Involuntary Emergency Admission (IEA) process. There are multiple drivers, but the IEA process starts an individual down a court involved treatment pathway as opposed to a clinically driven pathway. Changing that trajectory requires increased development of community and mobile crisis prevention and intervention capabilities, increased voluntary bed capacity, and greater coordination of the "front door" to care. Devotion of funds to the continued development of a robust community based crisis prevention and intervention system will decrease ED utilization, IEAs, and the volume of individuals boarding in EDs across the state, ultimately improving the goal of overall increased community tenure. We believe this to be an integral part of a consistently designed comprehensive crisis system that supports services across the continuum of care.

Building on the Crisis System of Care Model and systemic reforms in states like California, Colorado, Georgia, and Washington, a best-in-class crisis model emerges. Eight essential core system components ensure that individuals experiencing any behavioral health crisis can access appropriate services for prevention, resolution, and recovery/ reintegration. The components are:

1. **1-800 "Front Door":** 24/7 hotline able to provide phone-based crisis de-escalation and resolution: screening, initial assessment, triage, information and referral services; front entry into the crisis system, affording real-time monitoring, tracking and disposition of anyone touching the crisis system. Accommodation registries or proactive crisis plans can be housed within the 24/7 system for person centered care intervention.

2. **Mobile Crisis Units:** Adult and child specialty teams, inclusive of peers, who intervene within the community, facilitate crisis resolution, utilizing de-escalation techniques, and administer pre-screening assessments. Mobile teams provide an opportunity to triage and coordinate crisis follow-up care, including education and support to families

3. **Community-Based Locations:** Crisis walk-in capability and law enforcement drop off locations focused on providing crisis intervention outside of the ED. Community-based locations stabilize and connect individuals with sources of ongoing support and services.

4. **Integrated SUD/Medication-Assisted Treatment (MAT) Solutions:** Engage, partner with, and train key community stakeholders on effective ways to identify and interact with individuals in crisis with standalone addiction or concurrent needs; integrate processes to ensure that access to addiction treatment is readily available within the crisis response system, including follow-up, that is comprehensive and consistent, and provide referrals when needed.

5. **23-Hour Receiving Centers or Peer Living Rooms:** Small, diversionary options that offer a less restrictive, more recovery-focused approach for people in acute crisis but do not require hospital care. For individuals with SUD/OUD needs, short-term sobriety support may be a secondary gain of a 23-hour center. There are examples of these that are effective in rural Massachusetts.

6. **Providers for all levels of care; Availability of Urgent Access:** An array of services that facilitate needed throughput to individuals in crisis. Levels of care vary in relation to an individual's acuity level, support system, and immediate needs.

7. **Crisis Collaborative:** Law enforcement, local community organizations, faith-based organizations, and other local stakeholders working together to develop

and provide integrated, community-based intervention, care plans, and services that are comprehensive, culturally competent, strengths-based, and family-centered.

8. **System Management and Oversight:** Unifying organization serving several functions: technology infrastructure that facilitates access to needed services tracking availability of service availability, high risk member management, coordination throughout treatment episodes, provider contracting, network oversight; promotion of system wide data sharing and measurement of outcomes.

Applying these eight core components in New Hampshire will create comprehensive crisis systems and services across the continuum of care, and engage stakeholders, such as the Community Mental Health Centers, the Doorways, Integrated Delivery Networks, Law Enforcement, and Providers with individuals in or at risk of behavioral crises. New Hampshire is uniquely positioned to have a community mental health program infrastructure to support such a crisis system, but barriers of funding, regional variations and oversight / administration infrastructure must be addressed to ensure proper integration and consistency in approach.

The work to build a coordinated system is not easy, and takes support across stakeholders. Well Sense and Beacon promote the use and development of strong coalitions and collaboratives as means of early intervention, crisis prevention and recovery/reintegration support. Though crisis collaboratives, law enforcement, local community organizations, faith-based organizations, and other local stakeholders work together to develop and provide integrated, community-based intervention, care plans, and services that are comprehensive, culturally competent, strengths-based, person and family-centered. Models like the Chelsea Hub (https://chelseapolice.com/chelsea-hub/) are best in class examples of localized communities forming strong partnerships across diverse stakeholder groups to address the needs of individuals before an acute crisis arises.

Tactically, as the long term model is envisioned, developed and built, **near term strategies** must be implemented concurrently to buttress the existing system. We recommend starting with the following:

1-800 Front Door

Currently individuals in New Hampshire have multiple uncoordinated points of entry into the crisis system including CMHPs, 800 numbers, 9 Doorways, 211, EDs, safe stations and other points of entry. Unifying the point of entry across a single **24/7 hotline** simplifies access, screening, assessment, triage, information and referrals for individuals. Phone based crisis de-escalation and resolution for both behavioral health and substance use crisis calls can avert unnecessary ED use. Additionally, consolidated entry into the crisis system provides real time information of the status and disposition of each episode of care. A new 1-800 Front Door would not replace CMHPs or Doorways, but rather organize referrals into CMHPs, Doorways, SUD, and other system Providers.

Mobile Crisis Units

As the DHHS builds additional mobile crisis teams throughout the state, we suggest existing mobile crisis services abide by 3 core service components: 24/7 availability, community based interventions, and a primary focus on crisis resolution and stabilization. Crisis services need to be available at all hours, telephonically and field based, otherwise law enforcement and EDs will remain the primary point of entry for crisis management. Crisis teams need to be created in community and not in an ED. Crisis services based in EDs are used to determine the need for inpatient level of care or IEA rather than stabilizing and keeping the individual in community.

Community Based Locations

The root of the ED boarding crisis, in part, is because New Hampshire EDs, across the state, currently function as de facto behavioral health crisis centers. Well-advertised, 24/7 Community-Based Locations (CBLs) with clinical and peer support divert individuals in crisis from EDs, especially when the CBL has medical clearance capabilities. While New Hampshire Safe Stations are effective in getting individuals into treatment, they are not currently equipped or staffed to be a crisis management alternative to the ED. Mobile crisis and CBLs are natural partners in developing comprehensive crisis services and should be jointly procured. Joint procurement allows Providers to offer a broader continuum of services, and spread development and administrative costs across a larger service mix.

Q4. *Provide a description of the array of services that could be delivered through your recommended model, including by sub populations (adults, children, mental health, substance use disorder, co-occurring disorders), and if services focus on the immediate behavioral health crisis or address more broad social determinants of health.*

In Beacon's national crisis work they manage systems and organizations by bringing together Providers and other stakeholders to deliver high performing crisis systems. A high performing crisis system has the capability to service both adults and children and deliver services in a trauma informed way that is accessible for all populations and sub-populations as individuals representing all populations and all insurance payer types may experience a behavioral health crisis. The need for crisis services is not limited to individuals with severe and persistent mental illness—any individual could experience a crisis given the right set of circumstances. For many individuals the first contact with the behavioral health system is the crisis team and their crisis is multi-factorial.

As referenced previously, community and crisis collaboratives are a core component of Beacon's crisis work. These collaboratives, consisting of law enforcement, local community organizations, faith-based organizations, Providers, referral agencies, and other local stakeholders work together to develop and provide integrated, community-based intervention, care plans, and services that are comprehensive, culturally competent, strengths-based, and family-centered. Collaboratives play an important role

in identifying and intervening with individuals who are at risk of homelessness, have food insecurities or struggle with other social determinants of health. Collaborative interventions address issues upstream of a crisis situation preventing individuals from needing to engage with a more intense crisis service.

Q5. *Describe the expected ratio of services in this model of face-to-face versus phone or in-office contacts.*

NA

Q6. *Provide a description of how this model will successfully deploy mobile crisis services in both densely populated and rural regions within a designated timeframe, such as one-hour.*

NA

Q7. *Describe how this model will utilize best practices to meet the needs of currently underserved populations including people who identify as Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); transitional age youth and young adults; pregnant women with behavioral health conditions; and racial, ethnic and linguistic minorities.*

NA

Q8. *Include a description of any efficiencies that may be gained through the model.*

NA

Q9. *What other relationships or partnerships would support the implementation of this model? Include a description of both the role partners would play in program implementation/operations and financial sustainability. (Examples of partnerships include law enforcement, hospitals, and/or first responders.)*

NA

Q10. *Provide an overview of the technology and infrastructure needed to support this model.*

NA

Q11. *Provide a description of step-wise options to implement the proposed model(s). Include specifics regarding hours of operation and provision of services to all geographic regions.*

NA

Q12. *Provide details on the required team composition needed to deliver the scope of services proposed in your model, including staff competencies, areas of expertise, and specialty training requirements.*

NA

Q13. *Describe any challenges that need to be considered under this model.*

NA

Q14. *Describe any required data collection measures needed to address the effectiveness of these services.*

NA

Q15. *Describe the preferred tools to be used with the specified populations, including adults, children and youth who have suicidality, violence, mental illness, SUD, and co-occurring disorders. Describe potential tools used for assessing additional vulnerabilities including economic, physical environment, education, food, social context and healthcare (Social Determinants of Health).*

Our collective experience has demonstrated that preventive / initial screening and assessments to determine the individual clinical and non-clinical and social needs of our membership can be effective in triaging to the right service, offering an impactful opportunity to engage members where they are with the appropriate treatment modality. To this end, partnering with primary care and community based behavioral health and substance use providers who are skilled in helping members access the right pathways to care is a key to success. We have found that mandating a limited menu of acceptable screening tools for providers (to include both primary care and specialty behavioral health providers) helps to focus providers on tools and resources available to support membership. The Substance Abuse and Mental Health Services Administration publishes a comprehensive list of screening tools which can be utilized with specific

populations and sub populations: https://www.integration.samhsa.gov/clinical-practice/screening-tools#depression.

We recommend that screening tools be developed as a collaborative effort with the DHHS, MCOs, contracted emergency service and mobile crisis intervention providers. Standardized screening and assessment tools allow for evaluation of best practices, integrated care planning, defining service gaps, determining global quality improvement activities and provide a common platform for evaluating the success of crisis intervention services. Regardless of which of the screening tools is used it is important that the crisis team is able to triage the individual across a comprehensive crisis system.

Q16. *In your estimation, how much money will it cost to provide a fully integrated statewide mobile crisis response teams and how many individuals would your organization be able to serve?*

NA

Q17. *Provide a recommendation of funding model(s) to support the ongoing delivery of services associated with this model. Models may be, but are not limited to, a daily rate for a total cost; bundled service rate (identify which services), administrative rate/costs that pass to providers, and/or tiered Medicaid rates. In addition, what type of funding sources are available such as private insurance, Medicaid, general funds, etc.?*

NA

Q18. *Are there additional questions or concerns that are important for the Department to consider with regard to developing and implementing the recommended approach?*

Additional considerations include:

PCP support for lower level behavioral health needs:

As noted above, we believe in the importance of screening and initial assessment as a foundation for preventive crisis services. We recognize, as well, that many PCPs are able to (and in fact actually do) support members with low level mental health or substance use needs through prescription and / or in-house short term counseling resources. Thus, we recognize that support for these practitioners is crucial to the existing continuum of care, and suggest consideration of consultation programs offering support to primary care clinicians by psychiatrists, such as those offered in Massachusetts.

- Massachusetts Child Psychiatry Access Program (MCPAP) https://www.mcpap.com/
- Massachusetts Counseling Services for Treatment of Addictions and Pain (MCSTAP) https://www.mcstap.com/

Capacity:

Capacity must be available within the behavioral health and substance use delivery system to receive referrals and provide services to individuals who screen positive for needing crisis intervention services in addition to more routine care. If the system lacks availability of rapid access to behavioral health and medical treatment and social determinants of health services post crisis services screening, when need for comprehensive health care is first identified, the likelihood of an individual receiving the appropriate level of treatment and services decreases dramatically. The longer an individual waits for services the less likely resolution of the immediate crisis will be sustained.

Use of a core training curriculum:

The needs of the underserved populations can be addressed through the qualifications and training of the crisis teams, including clinicians, peers, first responders and law enforcement personnel. We recommend the DHHS consider a core training curriculum or requirements for all individuals employed at contracted crisis providers. A set of core competencies and, where applicable, certification processes, can tie the diverse and decentralized crisis workforce together. For all mobile crisis teams, and in particular mobile crisis teams for children, it is critical that the State mandate specialized training in strengths-based interventions for children in crisis and training for effective collaboration with parents. A certain level of education or clinical license is not required to learn and use the skills needed to respond effectively to a crisis response situation, but appropriate training is. Given the lean workforce in New Hampshire, it is essential that every contact with an individual in crisis, whether by phone or in person, be culturally competent and valuable.

As law enforcement personnel and first responders are regularly involved in crisis situations, the training needs for them cannot be overlooked. It is important that law enforcement and first responder personnel have access to appropriate and continuous training inclusive of debriefings and collaborative approaches for working with high-risk individuals.

Attention to the Ten Year Plan:

Parallel to the work required to build a consistent statewide mobile crisis response system, the Ten Year (TY) Plan must also be funded and adhered to. The TY Plan makes explicit the required steps and actions toward transforming behavioral health care in New

Hampshire. It is the right work to do, as it moves the state of New Hampshire closer to a system that holds individual community tenure out as the principal goal for behavioral health care.